Mental Health Medication Advisory Committee Meeting Meeting Minutes, Open Session November 30, 2016 at 9 am – 11 am		
MHMAC Meeting Minutes Open Session HP Enterprise Services Capital Room 6511 SE Forbes Ave, Topeka, KS 66619	**Members Present:** Susan Mosier, Secretary of KDHE, MD, MBA, FACS (Chair) Aaron Dunkel, Deputy Secretary of KDHE Vishal Adma, MD, MS, CMQ, CPE Nicole Ellermeier, PharmD Rebecca Klingler, MD Karen Moeller, PharmD, BCPP Charles Millhuff, DO Taylor Porter, MD **Members Absent:** Holly Cobb, NP Brad Grinage, MD **KDHE Staff Present:** Annette Grant, RPh, KDHE/DHCF Carol Arace, KDHE/DHCF **MCO Representatives Present:** Jennifer Murff, RPh – United Healthcare Jonalan Smith, Pharm. D., FASCP, – Sunflower William Mack, MD – Amerigroup Lisa Todd, RPh, BBA – Amerigroup **HP Staff Present:** Nancy Perry, RN	**Representatives:** Rick Cagan, KVC; DeAnn Jenkin, Comcare; Roy Lirdfield, Sunvian; Susan Zalenski, J & J; Mike Donaldson, Med Trak; Terry McCurran, Otsuka; Kristin Pargh, Otsuka; Katrina Ramjer, FSGC; Kyle Kessler, ACMHCK; Mitch Depriest, HGC; Amy Capbell, KMHC; Angie Zhou, Sunflower

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I. Call to Order A. Introductions B. Announcements	**Call to Order:** Dr. Mosier: Well, Good morning. We'll go head and get started. Thank you all for being here. I think because there's some new faces here that, we've got Annette Grant who is our new Pharmacist for Medicaid. So I think that for her benefit, primarily, that we'll go around and have everyone introduce themselves. I'll start with Aaron, who you already know. **Introductions:** Dep. Sec. Dunkel: Aaron Dunkel. Deputy Secretary for KDHE. Dr. Adma: Vishal Adma, Medical Director at KVC Hospitals. Ms. Arace: Carol Arace. Division of Health Care Finance, Administrative Assistant to you. Ms. Grant: Annette Grant, KDHE. Dr. Todd: Lisa Todd, Pharmacist with Amerigroup. Dr. Murff: Hi. I'm Jennifer Murff, a Pharmacist with United Healthcare. Dr. Ellermeier: Hi. I'm Nicole Ellermeier. I'm a Pharmacist with Med Trak Services. Dr. Porter: Hi. Taylor Porter. I'm a Psychiatrist and Medical Director at Katie's Way in Manhattan. Dr. Moeller: Hi. I'm Karen Moeller and I'm the clinical associate professor at the University of Kansas School of Pharmacy. Dr. Millhuff: Hi. Chip Millhuff. I'm a Child Psychiatrist at Family Service and Guidance Center, which is here in Topeka. It's a Community Mental Health Center. Dr. Klingler: I'm Becky Klingler. I'm a Physician with Pediatric Associates in Manhattan. Ms. Grant: Nice to meet you all. Dr. Smith: I'm Jonalan Smith with Sunflower Health Plan. I'm not actually Dr. Shoyinka. I'm	Sec. Mosier called the November 30, 2016 MHMAC meeting to order at 9:07am.

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	sitting in for him today and Angie Zhou is our new Pharmacy lead. Dr. Mosier: Very good. Well, thank you very much. **Announcements:** Dr. Mosier: In terms of announcements, I do want to remind people, so, the members of the committee are voting members, so our representatives from the managed care organizations are here as a resource if asked by the members of the committee for input, but not members of the committee. As a reminder, so it's at the request of the committee to respond to questions.	
II. Old Business A. Review and Approval of February 9, 2016 Meeting Minutes	Dr. Mosier: With that, we'll go onto the review and approval of the minutes starting with February 9th. Does anyone have additions, changes, or corrections to the minutes of February 9th? **Board Discussion:** Dr. Porter: Dr. Mosier? Dr. Mosier: [Yes?] Dr. Porter: I have a couple that were just typos. Not of particular interest. Dr. Mosier: Ok. Dr. Porter: Should I say those out loud or pass those on to somebody? Dr. Mosier: Go ahead. Dr. Porter: Ok. I wrote them down earlier. It mostly has to do with people with not being clear when we use the term 'NP' being transcribed as some other word. So on page 8, paragraph 2, there's something that says NPT. It should be NP's, 'N-P-apostrophe-S', instead of-not 'end piece'. Ms. Grant: Dr. Porter, I did not listen to February 8th; this was from Liane. I assumed she listened to it. Dr. Porter: No big deal. Page 14, paragraph 12, I think it says 'RMP' and it should be 'psychiatric	Dr. Ellermeier moved to accept the minutes as amended. Dr. Adma seconded the motion. The February 9, 2016 minutes were accepted as amended unanimously.

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	APRN'. And I'll be honest, I only read mine. Dr. Mosier: That's efficient. We'll make correction for a name spelling that 'Gary Hallmark' is H-A-U-L-M-A-R-K. Ms. Grant: What page is that? Dr. Mosier: There's multiple pages, I think. I'm sure he'd like to be part of that family. Does anyone else have any additions, changes, or corrections? Dr. Ellermeier: I would move to accept with the proposed changes. Dr. Adma: I second. Dr. Mosier: It's been moved and seconded. All in favor say 'Aye'. {Many Aye's are heard} Dr. Mosier: Any opposed - 'Nay'. {Silence}	
II. Old Business B. Review and Approval of May 10, 2016 Meeting Minutes	Dr. Mosier: We'll move to the May 10th minutes. Again, any additions, corrections, or changes? **Board Discussion:** Dr. Millhuff: I have one. Page 6, let's see here, there's a comment after my name, it says 'As a Child Psychologist'. It should say, 'As a Child Psychiatrist'. Dr. Mosier: Any other changes? {Silence} Motion to approve? Dr. Adma: I do. Dr. Ellermeier: Second.	Dr. Adma moved to accept the minutes as amended. Dr. Ellermeier seconded the motion. The May 10,, 2016 minutes were accepted as amended unanimously.

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	Dr. Mosier: It's been moved and seconded to approve the minutes of May 10th. All in favor say 'Aye'? {Many Aye's are heard} Dr. Mosier: Any opposed? {Silence} Dr. Mosier: Minutes for both meetings have been approved.	
II. Old Business C. Prior Authorization Criteria 1. Use of Multiple Concurrent Tricyclic Antidepressants (TCAs) – Review proposed clinical criteria for patients prescribed multiple tricyclic antidepressants.	Dr. Mosier: Now for the Old Business we do have the Prior Authorization Criteria that were discussed at the last meeting. What we want to do is go through a brief review of what was updated at the last meeting, which Annette will do, and then if there is any further discussion and then because these were discussed at the last meeting then they'll be up for a vote after that, unless there's significant changes. **Clinical Public Comment: -** No requests were received. **Board Discussion:** Ms. Grant: This has been brought back and forth. Originally they wanted to take off the ones that are highlighted because they are used for different indications. However, the Board brought it back on because they're still Tricyclic Antidepressants and still should not be on multiples of them. That was the main issue with it going back and forth. These are the same criteria as approved for the SSRIs and the SNRIs. As far as 2 or more currently or greater with the 60 days. Basically approving that, yes, the ones highlighted will be on this one and the criteria will stand as is. Dr. Adma: So did we initially take them off first? Ms. Grant: They were taken off, then put back on. Dr. Adma: The Board sent this back. Ms. Grant: Because, Amitriptyline can be used for migraine prevention or pain/other indications,	Dr. Moeller moved to accept the criteria. Dr. Adma seconded the motion. The criteria were approved unanimously.

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	however you still don't want more than one prescribed at a time. More than 2. That's why they said to go ahead and put them back on because the issue is they are still in the same class. There shouldn't be multiples in this class. Dr. Adma: So you're talking about 2 or more TCAs only or SSRI and a TCAs? Ms. Grant: TCA only. Dr. Adma: Two or more TCA only. Ok. Dr. Mosier: Maybe what we could do is if you could scroll up and just read the criteria to the Board. Ms. Grant: Sure. Two or more different TCAs used concurrently for greater than 60 days will require prior authorization: Peer-to-peer consult with health plan psychiatrist, medical director, or pharmacy director for approval. Dr. Ellermeier: So this allows them to switch agents? Ms. Grant: Right. Dr. Adma: Do you have any data in terms of; is that prescribed a lot? Ms. Grant: I saw that last week, someone asked about bringing data. I did ask Sunflower to see what they had. They had 9 members who are on two or more. Typically what we've seen is that all three MCOs are pretty much the same. So that would be like 27 members that are on two or more. Dr. Adma: That's a very, very small number. Ms. Grant: It is. I think the reason, also, is that Legislature said that they want all classes reviewed. So, we would still review it and make that decision. Dr. Adma: I don't see this as a problem with the Psychiatrist; maybe the Primary Care Physicians might do more of this than Psychiatrists. Unless somebody sees it different?	

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	Dr. Porter: Seems reasonable. {several board members agreeing can be heard} Dr. Moeller: I motion to approve. Dr. Mosier: Second? Dr. Adma: I do. Dr. Mosier: Ok. All in favor say 'Aye'. {Many Aye's are heard} Dr. Mosier: Any opposed-'Nay'. {Silence} Dr. Mosier: Approved. So these will be move to the next meeting of the DUR.	
II. Old Business C. Prior Authorization Criteria 2. Use of Multiple Concurrent Mood Stabilizers– Review proposed clinical criteria for patients prescribed multiple mood stabilizers.	Dr. Mosier: We'll move on to the *Use of Multiple Concurrent Mood Stabilizers*. **Clinical Public Comment: -** No requests were received. **Board Discussion:** Ms. Grant: This one was brought up last time, again, as one of the classes that the Legislature wanted us to go through each class. There's only 34 members out of 7,800 on more than one mood stabilizers; 3 or more. Discussion from the minutes last time, discussed whether or not we could monitor this; whether or not there were diagnosis they could put in; determine why they are on more than one; but the biggest concern was brought about maybe Stevens-Johnson Syndrome or pregnancy or people with seizures and making sure that the safety factor is with this. There was discussion that maybe we couldn't do this one because trying to track as far as the systems might	Dr. Klingler moved to table the criteria and review in approximately six months with the data- with Topiramate and without Topiramate. Dr. Moeller seconded the motion. The criteria were tabled to a later date.

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	not be able to do this. Even if it is something we want to monitor, we might not be able to do it from the system approach. Dr. Moeller: Let me ask you about; I wasn't here the last meeting; I was thinking like Topamax is in a lot of combination products now for weight loss, is it just Topiramate here or would it be, what if someone is on it with a combination product? So that's what I'm concerned about. A lot of these are like for headache prophylaxis. There's, I didn't know… Ms. Grant: That what part of the discussion last time because they couldn't figure out how to deal with this class. There's so much variance. Dr. Porter: If I might, I think that if it is more than one it might be an issue. I think that if it's three or more that's going to be a much smaller group. Dr. Adma: What's the data on this? Ms. Grant: From what Liane had said; 34 members had three or more. Dr. Porter: So, again, I think that's going to be uncommon enough that reviewing it seems reasonable. Dr. Adma: Does it have an indication though? Sometimes, as Karen pointed out, Topamax if the indication is for weight gain or if the indication is for a headache compared to a mood stabilizer that could be; then the neurologist might be prescribing Topamax. Dr. Moeller: Yeah, I don't know if Topamax should be on the list. Because, technically, it's not a mood stabilizer; all the other ones are. So, I don't know. It's got so many other indications. Dr. Porter: That's a great point. Why not have Keppra and other things on there if we're going to have other indication medicines. Dr. Adma: The other thing to keep in mind also is sometimes you do have patients on the combination of Lithium and Depakote, right? For Bi-Polars, and what if in those situations you use	

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	Lamictal for Bi-Polar Depression? Then that becomes three. Dr. Moeller: I could see the Lithium, Depakote, and then the Topamax is just on there, like, for something else. Dr. Adma: They have the potential where Psychiatrists manage these, where the patient is stable on Depakote and Lithium and then Lamictal is being used as a Bi-Polar Depression agent, then that becomes three. That's the only variation I see in this. Dr. Millhuff: Do you think that happens very often, Vishal? Dr. Adma: No. Very Rare. But it can happen. Dr. Porter: Again, if the numbers are to be trusted, and it's just 34 members that trigger this review, that would indicate it's a really uncommon issue. Therefore I think uncommon things are what we're trying to say should be explained or reviewed. Dr. Moeller: I guess but the Prior Authorization, if I read it correctly, then it has to be that a Neurologist or seizure diagnosis. So. Dr. Adma: With the Topamax? Dr. Ellermeier: I think that's an 'and' not an 'or'. Is it one or the other of those? Dr. Moeller: Because what if a PCP, like I said, prescribes Topamax or even Depakote for headaches. I mean, I agree. I mean, I guess like even with the Psychiatrist did Lithium and Lamotrigine, and then someone did Depakote or Topamax. Dr. Porter: I'm not sure… Ms. Grant: How do you want that to read? Dr. Moeller: I mean, does it have to be a Neurologist, or…?	

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	Dr. Ellermeier: I think it's one of the medications. And then they have to have a diagnosis of seizures, so it's both of them. I think the way it reads, both of those have to be met for them to get three or more. Dr. Porter: I think, what Vishal brought up, there might be some psychiatric situations where that could be an indication, the right treatment for a patient, uncommon. But it could occur in the absences of a seizure or a Neurologist being involved. So I don't see why we have to have that bullet on there. Dr. Ellermeier: What if it's those two bullets or the consultation with the Medical Director; what the other criterias… the TCAs? That bullet. So it would be at least one medication prescribed by or in consultation/collaboration with a Neurologist and they must have a seizure diagnosis *or* they have the … Dr. Adma: It's going to be very difficult for us to say that this can only happen if a consult with a Neurologist. Dr. Ellermeier: That's what I'm saying. We say either it's those two *or* it's the consult with the Medical Director situation. Ms. Grant: Or a consult with a Psychiatrist? Is that what you're saying? Dr. Ellermeier: No, the criteria for the TCAs? That criteria. So either they have a seizure disorder and are being followed by a Neurologist or it's for some psychiatric indication and there's a consult with the Health Plans' Medical Director. Dr. Adma: Quick question, Jonalan. You do have some PAs with specifically authorized for a specific indication or diagnosis, right? Dr. Smith: Correct. Dr. Adma: For Diabetes medications and others, right? So here, if we were to say Topamax,	

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	exception for three or more if they had an indication of headache or seizure. Don't have to have a consultation with a Neurologist at all. Headache or seizure as indication. Then it be used as a third mood stabilizer. Would that suffice? Dr. Smith: It would. My question on this criteria, as far as operationalizing it, is what is the safety concern? I think Annette mentioned some with the potential Stevens-Johnson and things like that, and as Ty mentioned, the limited number of patients. Is this one, for us, is there a safety concern sometimes with three and if so, what are we trying to prevent when we implement this? Is my question. Dr. Moeller: Do other States have a thing like this? Ms. Grant: No. From what Lianes' notes said, that this is just trying to meet the Legislatures recommendation that all classes be addressed. So, you could table it or we could totally agree to not do anything, but it's just, at least, we've addressed this area. Dr. Porter: Vishal, I think, again, if this goes forward, that we just take Topamax off. It's not an indicated mood stabilizer. And that's what the category says. Dr. Moeller: And I think there's too much…I see it so randomly but it's never…when I see patients get admitted on it, you know, they're for weight loss or headaches and so. Dr. Porter: It's used off label in Psychiatry, but that's an off label thing. Dr. Moeller: It never seems to be for mood anymore. So… Dr. Adma: I agree. But then the only problem that I see if it is taken off somebody could easily prescribe it and that would not come under the radar. Dr. Porter: Correct. Same thing if somebody comes in and their on any other anti-epileptic drug not up here. Phenobarbital, Keppra… Dr. Moeller: Zonisamide. Topamax and Zonisamide are very similar. So…	

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	Dr. Adma: Yeah, ok. Ms. Grant: So just take Topamax off and that would be… Dr. Porter: I don't know if we'd need a motion for that. If we're talking about it; it just doesn't belong. Dr. Adma: Chip, your thoughts? Dr. Moeller: I kind of wonder if we even need this policy. Dr. Ellermeier: Do we know if there is any data about people on four or more? You made a case for why there's three. Can you make a case for why somebody would be on four of these? Dr. Adma: No. Dr. Ellermeier: So, maybe that's where the limit needs to be. Dr. Moeller: I would be more happy with four or more cause you know just think about seizure patients, they're going to be on multiple agents…I just…there so many different…neuropathic pain, I mean, you've got Topamax, why not Gabapentin? Cause Gabapentin is now being used for Alcohol Use Disorder. You know, some people use it as a mood stabilizer for anxiety, there's so many anti-convulsives, and I think it's going to be really tricky. Dr. Smith: And just from an implementation stand point, these are kind of challenging with the 60 day time frame and things like that. And you start thinking about seizures more than mood stabilizers and potential titrations that could go over that; our system can't recognize that. It's going to be hard to code, is what I'm saying. Dr. Adma: I like the idea 'four or more'. Dr. Ellermeier: I think that's a harder case to make. Why do you have a patient on four? And then I	

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	would also be in favor of not having the criteria we currently have but have it in consultation. Exactly what the TCAs say. That criteria. Basically have a reason. Dr. Todd: And just from a systematic stand point, to kind of piggy-back off of what Jonalan was talking about, the way the criteria is written right now as far as one of the medications has to be with a Neurologist and the other bullet is about the diagnosis, most of these are claims that have already happened and then when that third claim comes in, if it isn't timed just right, or if that isn't the Neurologist on that specific claim, it's just the computer doesn't work that way. So if we switched it to the way Nicole said and made it… Dr. Adma: Four or more? Dr. Todd: Four or more and then also just do the consult like we do the others then that would be. I'm just a little nervous about blessing the criteria and then us not being able to put it into the computer correctly. Dr. Adma: My fear only is in rural Kansas getting a consult with a Neurologist is going to be tough thing. So I would rather have the Psychiatrist explain why they are doing that. Dr. Moeller: And do we want to keep Topamax? Do we want to add anymore? I mean… Dr. Porter: I think add all of them or take Topamax out. Dr. Moeller: I wonder how many would hit this. I don't know. I'm not leaning towards this policy. I mean, I agree the four or more is better, but I think it's complicated. Dr. Mosier: Did we have data on the three or more at all? Was that the 34? Ms. Grant: Thirty-four members. Dr. Adma: Across all three MCOs. Dr. Moeller: I wonder if four or more are even going to hit it.	

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	Ms. Grant: It's a very small percent. Dr. Smith: I would say, also, just from the MCO stand point, we do have retrospective reviews on some of these things. This is one where we had a retrospective review in place for 3 or more. Where we would do outreach to the prescriber and be more proactive on our side, versus where this would set up a hard stop at the pharmacy so the patient couldn't get it. I don't know which way the committee is leaning. Which way you'd want to go with that. Might be more in line to what you're saying, Karen. Dr. Ellermeier: I have a question. If we decide to not move forward with the policy today on this drug class, can we revisit it at a later date if there's an issue? Dr. Mosier: Certainly. Yes. Dr. Ellermeier: So, I could move to not approve this. To do nothing with this class at this time. Dr. Adma: But also to add a retrospective review too. Something like this. So that way the MCOs could… Dr. Smith: We have that. Dr. Ellermeier: They already have it. Dr. Adma: They already have that? Dr. Ellermeier: Yes. Dr. Smith: That is something this committee could direct us to do more formally if you felt compelled to say, this is what we'd like you to do. Dr. Todd: Or we could bring data back for the last 6 months to see how many are 3 or more; 4 or more; is this a problem; and you guys could discuss it again.	

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	Dr. Millhuff: I just want to make a comment. I really like what you just said, Jonalan, about the review rather than the hard stop at the pharmacy if you had that complex of a regimen of medicine. Quite frankly, I might want to talk to someone about what would be the best strategy to change this. Talk about how would I go about taking them off of one and what not and can we approve a set of criteria like this without having a PA connected to it? Just say we approve it for review. Like formally, like Jonalan was just saying. And I'll just add to that, the other concern I have is a hard stop at the pharmacy; the time it takes to do the prior authorization process and to get a response. What if you have a gap in coverage for these meds that could result in a withdrawal seizure? I have the same concern for anti-psychotic medicines as well. Dr. Mosier: Do you know, with the DUR, do they just do the prior auth or do they do procedure, process, recommendations that they approve as well? Ms. Grant: I've not seen anything that says we do a certain procedure. We do Step Therapy but we don't do like what you're talking about. I don't think that we could not do it. Dr. Smith: The MCOs present an annual report to the DUR Board. All three of us. Each individually present our retrospective DUR reports. What we've chosen to date, I don't think we've been directed by the DUR Board for any specific areas, but we're kind of focusing on the areas where we've identified opportunities. We could easily add something like this just to add to that list without a formal request. If you'd like. Dr. Mosier: We've got different options on the table. We've got tabling it to a later point in time. And gather some data. Maybe 6 months and take a look at that. There's more of a process rather than a PA, and recommending that. And then there's do a report already and have it not be a formal process that goes through approval here and through the approval of DUR. I'll just put that back out as the question to the committee. Dr. Klinger: I would move that we table it till we have more information. Dr. Ellermeier: I would agree. I would like to see data on three or more versus four or more. Maybe with and without additional agents. Just so we can kind of get an idea of is there a problem that we	

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	need to address or not. I don't feel like we have quite enough data to do that at this point. Dr. Porter: And by additional agents, you mean to include all the anti-epileptic category. Dr. Ellermeier: I think we remove Topiramate or add them all. And look at data both ways. Dr. Millhuff: Can we also find out who is prescribing these? Dr. Todd: Can I ask; how long back do we want to look for data? Do we want to look at a year? Because if we're talking about 60 days, then, you know, the 60 days concurrent, then if we just look at the last quarter that's not going to give us a very clear picture, right? So do we want to go back a year? {Several individuals say 'yes'} Dr. Porter: I would say if we want to look at the AEDs as a category, my understanding is that triple therapy is common in Neurology for seizure disorders. So if we include all those meds, we are going to get a lot of Neurological data. Which data's not bad. Dr. Todd: It's just a lot to cipher through. When may not be super useful, so do we want to take Topiramate off and then just pull based on those that are listed? Dr. Adma: I would prefer that compared to adding that. Dr. Moeller: We could do with or without Topiramate. Dr. Adma: Ok. Dr. Todd: You mean run it both ways? Dr. Adma: Yes. Dr. Murff: Just that list with and without Topiramate?	

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	Dr. Adma: Yes. Dr. Moeller: I second the motion to table. Dr. Mosier: We've got a motion to table and review in approximately 6 months with the data, with Topiramate/without Topiramate. The second for that? Dr. Moeller: Second. Dr. Mosier: Ok. All in favor say 'Aye'. {Many Aye's are heard} Dr. Mosier: Any apposed-'Nay'. {Silence} Dr. Mosier: That is tabled.	
II. Old Business C. Prior Authorization Criteria 3. Opioid Dependence Agents- Review request by DUR	Dr. Mosier: Now we have *Opioid Dependence Agents*. Apparently the DUR had a request and I'll have Annette explain that request. Ms. Grant: Yes. This had been approved by this Board previously and then it went to DUR. The concern was Ativan used for alcohol withdrawal and if you say that they can't have that then what are the Physicians supposed to do? They didn't want a straight denial. They wanted something like a sub-PA like in certain instances you could use benzodiazepines. The only other problem with that is that it goes against FDA labeling. So, if we approve something that is against FDA labeling then that puts us in a position. What this Board passed would deny, but the DUR said we don't want a straight denial on benzodiazepines. So, bringing it back here. **Clinical Public Comment:** - No requests were received. **Board Discussion:**	Dr. Ellermeier moved to accept the criteria as amended. Dr. Adma seconded the motion. The criteria were approved as amended unanimously.

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	Dr. Moeller: Alcohol withdrawal should be treated in the hospital. Ms. Grant: That's just one of the examples I was given. There are times when you need benzodiazepines. They just threw that out there. So how do you set the criteria for when you can and cannot? Dr. Adma: There are some outpatient programs who do. Dr. Moeller: I know. Dr. Adma: So FDA says no benzos? Dr. Smith: It's contra-indicated. Dr. Adma: It's contra-indication? Dr. Smith and Dr. Moeller {talking over each other}: Black box warning. It came out the end of August. It's serious. Ms. Grant: There are some deaths associated with it. Dr. Todd: That was discussed during DUR meeting but they still didn't want to approve it. Dr. Moeller: So as this reads; is this what we did or what the DUR recommended? Ms. Grant: This is exactly how you guys approved it last time. Dr. Adma: We did but they said we need to; we're taking it back. Dr. Moeller: I didn't know if these were their recommendations. Dr. Ellermeier: I think our discussion was primarily the cost of these medications. The benzos	

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	somewhat low cost with the patient. Ms. Grant: They'd pay cash is what I've deduced. Dr. Smith: Annette, if I recall right, I think you said this, the criteria wasn't concerning to them, the idea of it, it was more of they didn't want it to be an absolute 'no'. They wanted it to be a PA review as opposed to just a 'you can't get this drug if you're on a benzo'. But I don't know from, like you said, with the FDA black box warning, what a PA reviewer would then look at and say 'ok, it's a black box warning'; I don't know what we'd use to say 'ok you can have it this time'. Dr. Adma: There are black box warnings for kids with anti-depressants but we do prescribe them, we explain that. Dr. Smith: I guess it's risk/benefit. Dr. Adma: Yes. That's what they're looking at. Dr. Ellermeier: For the MCOs, for you guys to operationalize, like if we said 'benzos need to reject if they're on Soboxone and require a PA', is that something you can tease out? Dr. Todd: That would work if the Soboxone was filled first. Right. First in is the golden. So if the benzo comes in first before the Soboxone, then it's just going to pay. Then Soboxone will come in, and then the Soboxone would be denied because they got the benzo already. But if they did it the other way and got Soboxone… Dr. Adma: What's the data on this? Ms. Grant: First quarter of 2015, fifty five patients were taking both. Half were prescribed by more than one doctor. So pain management plus PCP. Dr. Todd: A little more than what I think we suspected for it being this fatal reaction. As far as the claims, it would just be the order of the claim. So, I guess to answer to your question, we can defiantly deny the benzo once the Soboxone is on board.	

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	Dr. Ellermeier: Because when you approve the Soboxone, you could put in to block the benzo. Dr. Todd: We would just block that as a rule on that drug in general regardless if a member had Soboxone or not. Like if the benzo claim comes in and it would look back in history to see if that member ever got Soboxone. At whatever 'look back' window we want to put. Then we could deny the claim at that point. Dr. Adma: Is it automatic denial or is it prior authorization where the Psychiatrist explains why they are doing whatever they are doing? Dr. Todd: Well, both are an automatic denial. That would trigger that. The pharmacy could let the doctor know 'hey, this denied. It requires PA.' and it would start the normal PA process. Dr. Porter: If we're talking about this issue about alcohol withdrawal. Then the 72 hours or so to do a review is the period of time you're probably most worried about. We're also talking about outpatient pharmacy claims; you can do what you want in a hospital setting. Dr. Todd: Correct. That's a good point. This is just at your retail pharmacy. Ms. Grant: Jonalan, do you remember other areas? That's just one I remembered them saying. Dr. Smith: It was just one of the DUR Board members, I think, that felt pretty strongly about it. Dr. Todd: It was one of the pharmacists, I believe. Dr. Smith: But you make a good point. I think that might be an option, I mean just trying to recall the conversation, I mean 72 hour allowance. Dr. Todd: But then there's that grey area. Dr. Smith: It's hard to operationalize.	

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	Dr. Todd: It's a black box warning. For 72 hours, do you take that risk? Dr. Porter: I think one thing that's going on is that there is more and more of a move for substance abuse programs to have medical detox as part of their program. It's becoming state of the standard of care. It's not the case of all of them now. But in that kind of setting, if it's a residential treatment, they would use a pharmacy rather than like in... And they would have somebody that might come in on Soboxone and want to detox them from alcohol or for benzos. A detox protocol would be with benzos. So I'm not, that doesn't change the fact that it's a black box warning, but that would be the clinical situation maybe the DUR member was been looking at. Dr. Todd: So would those prescribers be a certain type of prescribers? Or affiliated to a certain; I'm trying to think. Dr. Porter: I'm thinking of just my; when I was at Valeo, we didn't do medical detox but there was a lot of pressure to do it. It was under discussion a number of times. That's what it would look like there; it would be a prescription at the pharmacy general window which would look like an outpatient prescription even though the person was in a residential detox program. Dr. Adma: Any of you prescribe Soboxone? {Several 'No's are heard} Dr. Moeller: You have to be a prescriber of the Soboxone. So would the benzo prescription also have to be from the same prescriber? Could we say? Cause, how many did you say? Most of them were from different prescribers? Ms. Grant: Half of them were prescribed by more than one doctor. Dr. Smith: There you go. That fixes the biggest concern, right? When each prescriber doesn't know what the other is doing and it results in a cocktail. Dr. Ellermeier: So could the requirement be that the benzo denies if it's from a different doctor? If it's the same doc, let it pay. If it's from a different doctor-deny.	

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	Dr. Moeller: And it could only occur for a certain time period? Dr. Ellermeier: Just not, if it's from a different doctor. Dr. Adma: If it's the same doctor… Dr. Ellermeier: Same doctor, let it go. Dr. Moeller: To prescribe Soboxone you have to be trained. So that's only going to hit specific doctors. Not a lot of people have the; I don't know the numbers. Dr. Todd: I have the feeling a lot of these would probably be more like the patient may be on benzo before they go to the doctor that sees the Soboxone, which is what I think you're getting at, so just thinking out loud, the patient's already received the benzodiazepine and then they go to get the Soboxone, so then we'd have to worry about that. Dr. Smith: It'd be a PA right? So then it'd be a document saying 'I'm going to continue this' when they write the Suboxone to continue the benzo then it would be approved. It wouldn't be an auto. Ms. Grant: So you're saying 'will deny if not by the same prescriber.'? Dr. Adma: So what if they have comorbid, PTSD, panic attacks, and stuff and they're being stabilized on the benzo? Dr. Ellermeier: I think what we're trying to do is make sure the doctor prescribing Soboxone is aware of the benzo, I think is the main point, and are willing to prescribe both together. Dr. Adma: Yes. So could we do that if it was the same doctor? Dr. Smith: Yes. Dr. Adma: And they're aware of the list? So let's send this back with that change and see what	

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	happens. Dr. Mosier: So I see some operational questions going on over here. Dr. Todd: Yes, we're trying to cipher and see if we can get it. Dr. Smith: Just to be clear, not knowing all three of our operational systems, I do not believe this would be or likely to be an auto PA. Meaning the Suboxone would immediately pay and the system could recognize the benzo written by the same doctor. It would just be a PA. And it would be reviewed as a paper saying 'I'm continuing the benzo and this', just like a normal PA. It wouldn't be an auto PA. If that's what we're thinking. But our turnaround time could be under 24 hours. Dr. Todd: We could do that. Dr. Smith: It's a pretty reasonable review for a small number of patients with a black box warning. Dr. Mosier: Jennifer, United can do that then? That way? Dr. Murff: I would need to take it. Dr. Smith: You could do that PA, right? Dr. Murff: Well, yeah. Dr. Smith: Just not an auto PA, potentially. Dr. Murff: Yeah. I'm just not sure how we would, if we are going to deny it for the benzo and Soboxone, I don't really know that we could do anything based on prescriber to change that. You know what I'm saying? Dr. Smith: At the point of sale. Dr. Ellermeier: It would default to a manual review at that point. It would deny.	

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	Dr. Murff: But it would have to be a hard stop. Dr. Todd: I think maybe where you're going also that if it's a PA, sorry, this is getting into operational piece, but if it denies for PA, then it takes away the computer's ability to do a look back. Somebody would physically bring up a member's profile and look to see and it would be a manual review by whomever is handling the PA. Dr. Smith: But honestly, this drug already does that. Because the existing PA criteria, you have to do a PA anyway to meet all those other bullets that were already on there. This is just adding one more criteria to that review. Dr. Todd: That's correct. Ms. Grant: So changed as is-if not ordered by the same prescriber? Dr. Ellermeier: I would move to accept with the changes. Dr. Adma: I second. Dr. Mosier: All in favor say 'Aye'. {Many Aye's are heard} Dr. Mosier: All opposed-'Nay'. {Silence} Dr. Mosier: Ok. We'll send it back to the DUR with this change. Dr. Todd: Thanks for letting us talk through that.	
III. New Business A. Prior	Dr. Mosier: Alright, we'll move on to new business. We've been talking about wanting to go through the antipsychotic dosing limits for children. We've got two categories. And so I'll have you	Discussion of this criteria only.

	DISCUSSION	DECISION AND/OR ACTION
Authorization Criteria 1. Antipsychotic Dosing Limits for Children– Review proposed antipsychotic dosing limits for children.	pull up the first set of criteria. Ms. Grant: So the first one is, there was discussion about what are the limits for the children. We have them for the adults but not for children. We've not discussed the age for children. Is it less than 13 since some of our other standards are by 13? There was discussion about using the Texas document, that I think maybe Dr. Millhuff had given and maybe putting in a min and a max. So, I did do that, and I'll pull that up. I took every drug that was on the criteria that we already had and did the initial dose and then the literature based maximum dose, they had two in there. One was the FDA approved and the other literature based. I chose the literature based because I figured that was what you'd probably go with. So I took every drug and put the initial dose and the maximum dose, cause there was discussion about could we adopt Texas' data and use it as our own for antipsychotics. So it has all the age ranges. Anything in there with italics, the Texas state did not have it so I just pulled it from facts and comparisons. There's, I don't know, twenty drugs or what not but I went totally off the Texas document and then what they didn't have I went by facts and comparisons data. I guess the question is, do you want to adopt the Texas information as is, or how would you like to do this? **Clinical Public Comment: -** No requests were received. **Board Discussion:** Dr. Moeller: Was this given to us? Ms. Grant: Dr. Millhuff had; gave the last time. Dr. Millhuff: I sent an email. Dr. Moeller: Oh it was email, it wasn't in the minutes. I have that Texas data. It was done very well. I just didn't get to review the dosages before the meeting. Dr. Millhuff: I brought some more copies of this. I'm glad that you put all this information. But since I took the time to copy this, why don't I share this with the group here. Because, interestingly, they also add quite a fair amount of additional information about monitoring ideas and strategies.	

	DISCUSSION	DECISION AND/OR ACTION
	But I also want to pass around one more thing because there's several states, Illinois is using a very similar set of criteria like this, in fact I talked to Dr. Naylor, yesterday, via email. They use the same sort of strategies to put together their overview of meds. I compared the two last night and they're quite similar. I also looked at what Florida is doing which theirs is a little bit more simple in its outline. What they have is basically, I'll send this around, all the medicines that they approved for children and adolescents, they break it up in six to eleven, then twelve to seventeen, and just give a maximum dosage for each of those age categories. It's a little bit easier to read than this one. This one has a lot more detail. Ms. Grant: I just went off the document that you had given previously. Dr. Millhuff: Exactly. But the numbers between the two match up pretty good. Pretty good. Also attached is one that is for the two drugs that several of these states are approving for children younger than six which is Risperdal and Abilify. But I'll go ahead and send that around too so you can just see how they break that out as well. That being said, one thought that I had, something that you were just saying Annette, is could we break up the age range, first of all, on our dosing limits to three categories, which I, from what I see as a common theme in other states is defining it from four to five, and then ≥ six to eleven, and then ≥ twelve to seventeen. Ms. Grant: That's four to five, greater than six and under eleven, and then twelve to seventeen? Dr. Millhuff: Greater than or equal to six to eleven and then greater than or equal to twelve to seventeen, just to be really specific. And so then if you look the second document I sent around it kind of makes it easy to kind of get some top numbers for all three of these groups. So, I think that these dosages make sense in my experience and collaboration with other Child Psychiatrists and other prescribers. I'm curious what other people think about these dosing limits though. Dr. Porter: They're essentially the recommended adult maximums would be the equivalent to the older dose age. Dr. Moeller: That's what I was just thinking. Dr. Millhuff: Right. Which I am not as concerned about the older range as I am the elementary	

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	school age and preschool age kids. Just a personal comment. Dr. Ellermeier: If that's the case, I would think maybe the older, twelve and older should just follow the adult limits. Dr. Moeller: We do have some above the maxes in the adults? Like, I think, Abilify at 45. Dr. Adma: At 30. Dr. Moeller: Clozaril, Clozapine is 600, the max, I think is at 900. So there are some doses. Dr. Adma: The other thing to think about is what about less than six. Dr. Millhuff: So less than six, I also wanted to add another way of thinking about this. There was a little bit of discussion about this in our last meeting. Could we put in a minimum starting dose, I'm sorry a maximum starting dose. So that, not only are we looking at the max they can take, but where we should start. Because that's a serious problem with some of these kids starting too high. I just looked at different data and had some specific numbers, I'm just going to say this out loud, if you could see it on the different documents I sent around but really the only two antipsychotics that I'm seeing approved by other states in children four to five years of age are Risperidone and Aripiprazole. I think that that makes sense. Given the limited data that we have with these meds. Ms. Grant: In the Texas document that they did they said under three and under five and they put those drugs as the only ones that could be prescribed. Dr. Millhuff: Right. So you probably, maybe you put it up there, but for Risperdal the starting dose if their less than 20kg in weight it would be 00.25mg per day. I have found with Risperidone, if we try to go lower, which I have tried, breaking it in half, it's very difficult to break some of those tablets in half. The Texas group just went 00.25; the Florida was a little bit more conservative at half that dose. Yeah, but I think that would be ok if you're talking about a four up to six year old. Ms. Grant: So you used the Texas dose for the four to five year olds?	

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	Dr. Millhuff: Yes. I kind of this weight differential they came up with. They're basing this, I think, on some evidence. If the child is less than 20kg start at 0.25, if they're greater than 20kg in this younger age range it could be allowed to start at 0.5mg. Dr. Ellermeier: Could I ask a question? So what I think that means if we're doing weight based approval, I think it would have to be a hard stop. So the medication would have to be reviewed. Because you guys would need to review that, right? Dr. Murff: Once it would hit a PA and we would manually ask the provider. Dr. Millhuff: I'm not really convinced it has to be that, that we have to include the weight, but we could just err on the side of being conservative and say it has to start at 0.25. Dr. Ellermeier: It stops otherwise and they have to say why using the .5. I completely agree, I think the initial dosing is important. We want to make sure prescribers aren't starting too high. But I also want a balance like how many hard stops are we going to make happen for prescriber if we're also going to have a top dose for maintenance as well. So, just something to keep in mind how their able to operationalize that. Ms. Grant: Or a hard stop for younger than six years of age. Then you could weed out the rest after the hard stop. Dr. Smith: But we already have a hard stop for kids under six. So really, this could just be additional criteria of 'must document weight based dosing not to exceed…'. Dr. Ellermeier: That would make sense if it's already being reviewed. Dr. Adma: I really like what Chip has presented. This is, Florida is actually using this maximum dose? Dr. Millhuff: Yes and they just updated that this year. Dr. Adma: Ok. Good.	

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	Dr. Smith: I should clarify; we don't have a hard stop on Psychiatrists currently. Dr. Adma: Board Certified. Dr. Smith: Board certified Psychiatrists. Dr. Millhuff: Jonalan, what is the hard stop? Dr. Smith: Just PA required. Dr. Millhuff: If an antipsychotic is used for this age range? Dr. Smith: Yes. Yes. I think you have the criteria, Annette. Ms. Grant: I'm sorry, what was that? Dr. Smith: I don't know if you have that criteria that you could pull up that was approved by the board. It was for six and younger, it just said, requires a peer-to-peer consult for under the age of six. Dr. Millhuff: Unless you're a Psychiatrist. Dr. Smith: Unless you're a Psychiatrist. Dr. Millhuff: Neurologist or Dr. Klingler: DB? Dr. Todd: No, that's the Gold Card. Dr. Smith: For the non hard stop, it's Psychiatrists only. You do have to do it if you're Behavioral…	

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	Dr. Klingler: Developmental-Behavioral. Dr. Smith: Yes, but that's a criteria, you'd still get the stop. They could get it approved but they're not gold carded. Dr. Adma: I remember we included that. Dr. Klinger: Yeah, I thought we included the Behavioral/Developmental. Dr. Smith: You'd have to do PA and you could still get it approved through the PA process but a Family Practice Doctor could not get it approved through the PA process. Dr. Adma: We didn't include Family Practice, but we said… Dr. Klingler: Behavioral/Developmental Peds had it. Dr. Smith: But they're not gold carded. Meaning there's no PA. Dr. Klingler: We talked about that. Dr. Smith: We didn't actually talk about the Gold Card at all at the meeting as far as policy. We actually implemented that in August before these rolled out outside the DUR Board and I think that's an agenda item actually. Dr. Ellermeier: I think what they're saying is if they are Board Certified it will go through without a PA. If they're not, it will stop on the PA and it has the peer-to-peer consult for the specialties. Dr. Adma: As we discussed this is what I remember reading is we wanted to include the Behavioral Pediatrician, which is a small number. Dr. Klingler: Yeah, there's three in the state. Dr. Ellermeier: Right, but they would still require a PA. But, they get approved.	

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	Dr. Klingler: Yeah, but they're probably the ones doing most of the Risperdal, I'd say, because they're dealing with Autism diagnosis. So I would think they would need to be included in that. Dr. Ellermeier: In the Gold Card? Dr. Adma: Yeah. Dr. Klingler: I think there are even fewer of them than there are Child Psychiatrists. They're dealing with a very specifically focused case. The ones in the state are Board Certified, I think. So that they should be able to… Dr. Ellermeier: Is there three of them? Dr. Klingler: I think there's three of them, maybe four. Ellerbeck, Peters, at KU and KC. Allen and Kerschen. There's two in Wichita and two, I think, in Kansas City on the Kansas side. There's more in the Children's Mercy program and I don't know how they are inter-acting with Kansas versus Missouri. Dr. Adma: Do you have any data in terms of prescriptions for these age ranges? For example, Abilify, what are the maximum doses that are being prescribed? Is there a way to get that? Dr. Smith: It's not that hard because we'd have to manually review it but the volume of kids under six is low enough. I mean, we did look at that data before. I think Risperdal and Abilify were more in line, it was the concern we had a four year old on 15mg of Zyprexa, which would not hit this, but the ones where they are using Abilify. Dr. Adma: I like this but I'm not sure we want to approve this without knowing what the prescribers are doing. What do you think? Dr. Ellermeier: I would favor looking at data that mirror the Florida max doses. Like, how many do we have that are above those max doses?	

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	Dr. Adma: The data will get that. But I think this is a good starting point. Dr. Moeller: I think this is good too. Were you saying on this, the one that you made, that you used facts and comparisons for additional? Ms. Grant: If it wasn't on the Texas document. So, I guess my question is, this document from Florida doesn't have four and five year ages. Dr. Millhuff: On the back. Dr. Adma: On the back, second page. Ms. Grant: Ok. Ok. So you want the number of patients who go over this? Dr. Adma: Yeah. The only change we talked about is the 0.125; Chip is proposing 00.25, right? As a starting dose? Dr. Millhuff: What I'm saying… Ms. Grant: Like the Texas document on Risperdal. Dr. Millhuff: Right, Risperdal you couldn't start on a dose greater than 0.25mg total per day for Risperdal. For Abilify, you could not start with a greater dose than 2mg per day. Dr. Todd: I'm concerned, as far as operationally; I may have to go back to my PBM to find out if we can really do that. Because if we do, just to make sure I understand, if we do a dosing limit at the beginning, but later they could get a higher max dose, right? Then I don't think we have that type of tier capability that it's always going to hit that low one first. You know, so all of them will deny. Dr. Ellermeier: If they're already hitting for like an initial review, could the initial dose for under six be a manual review and not systematic? Because they should already be hitting. Then, instead of doing an initial dosing for the older age groups, just do a max dosing.	

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	Dr. Millhuff: I'm thinking right now for the adolescents and the school age kids don't do a starting dose quite yet. I just particularly want to make this a point for our preschoolers, so we have a starting dose just for that small group. Dr. Todd: Most computer systems, and I can't speak for the other two, but like if there is any kind of minimum dose, it would usually deny that you're not giving them enough. Like you're giving them a low, like, too low of a dose, like if you wanted everything to start at 00.25 or whatever it is, then the claim would deny if it was submitted for lower as a opposed to a first tier of a max. Ms. Grant: That won't happen because we're actually going above the dose. Dr. Ellermeier: I think it would have to be a manual review for the preschoolers and not a systematic. Dr. Todd: I agree. Ms. Grant: So let me clarify, the only two drugs that we're going to approve of for less than six years of age is the Risperidone and Aripiprazole. And then we'll have to have the maximum dose which will be the 00.25mg, well, the starting dose 00.25 for Risperdal with a max of 1.5 and then.. Dr. Millhuff: Right. I'm curious what Vishal thinks. Florida has 1.5 and Texas has 3. For a preschooler. And I'm more comfortable with the 1.5 so I would recommend that dose. Ms. Grant: So change the starting but leave the max for Risperidone? Dr. Millhuff: Say again? Ms. Grant: Change the starting dose to 00.25 and leave the max at 1.5. Dr. Millhuff: Correct. Ms. Grant: And what about Aripiprazole?	

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	Dr. Millhuff: Starting dose 2mg per day and then the max would be 15mg. Interestingly what I found in that for Aripiprazole that 15mg was the dosing limit not just for the preschoolers but all the way up to eleven. I don't mean to make this complicated, but, these are just ideas that other people are utilizing. Those numbers seem reasonable to me. I guess you could just define it if we had three different categories, simply say with Abilify you can use up to 15. Dr. Adma: The only thing I would like to add is a kid is getting started on these medications say at four and they've got two years with this, what if they've used both of them and their not responding or it's not effective would they be eligible to use the Zyprexa? Dr. Moeller: I was thinking, cause currently our guidelines if they're under five they and they don't have the Gold Card? Dr. Ellermeier: I think there's some. I think that if they're under that age, it's a peer-to-peer. Dr. Moeller: But it could be any? Dr. Ellermeier: Yeah. Dr. Moeller: But now we're saying you can only prescribe these two. Correct? Dr. Millhuff: That's what I'm saying. Dr. Adma: So maybe we could modify and say we should try these two and then if they fail, then maybe go to others? Dr. Smith: The other thing that would happen is you have an opportunity for appeal. The original prior authorization review, if you requested Zyprexa, if you went that route, and said they can only be used up to age ten, and then the initial prior auth would be denied, then you could appeal it. In an appeal there's usually some kind of literature where you say 'hey, these are case studies that Zyprexa has been used for seven year olds and I'm trying to treat.' But that's the system you'd be setting up.	

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	Dr. Millhuff: From a system standpoint also, if the prescriber wrote the initial prescription with a titration schedule, as simple as start at 00.25mg for four days and if tolerated increase to 00.25mg twice a day. Would that prescription go through? Dr. Smith: If you set the limit? Dr. Millhuff: If you set the starting limit. Dr. Smith: There's really kind of two options on how we could code that. We could just code as part of the PA review. And say during the manual review that the final dose exceeds the limit or not. Or we could do a limit based on, basically it just takes the number of tablets times the milligrams divided by the days supply, so it's not smart enough to know the titration in that from an automatic standpoint. Dr. Millhuff: And that's where we get at the limitations of this PA process. Dr. Smith: Right. Dr. Porter: Another thing. It's a small matter. This is dosing and also monitoring going forth in our guidelines and I don't think that waist circumference is something we want to have on there. Dr. Adma: I agree to that. Ms. Grant: Could we just do the dosing on this and then next time we can evaluate the whole. Dr. Millhuff: So getting back to this younger age, I just, I don't know if you want to call this 'fun facts', but if you turn one of these pages over, it was the one antipsychotics, the Texas one, it's more detailed, Chlorpromazine is approved. There's comments about it being used in preschoolers with specific guidelines as a PRN as well as Haldol. To be thorough that we've got the typical antipsychotics on there as well, do we want to include any of that as well? Dr. Ellermeier: Did we put dosing limits on the typicals for adults?	

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	{Several people talking at the same time} Dr. Adma: Previously we did not, but later we did. Dr. Smith: They are really high though. The atypicals there was more evidence, more case studies. Ms. Grant: All the adult limits are up there. So I think this is how you want; six to eleven years and under six. And we'll only put a dose for the Aripiprazole and Risperidone in this column? Dr. Adma: No, we should have one more column that says twelve to seventeen. Ms. Grant: There was discussion about of having the twelve to seventeen with the adults. Dr. Adma: No. No. Dr. Moeller: I think we should still have twelve to seventeen because we have above maximum ranges in the adults. Some of these as you look are; I don't know if we can justify. Dr. Adma: And Clozapine for the adults is 900. Dr. Porter: And generally speaking the heroic dose is going to be for someone suffering with schizophrenia and it's going to be an unusual person that has graduated to that degree before they are eighteen. Dr. Mosier: I do have a question because you brought up four to five rather than less than six. And I need to confirm. In our prior auth criteria did we exclude two to three? Has it already been dealt with? Dr. Smith: Right now it's just under six requires a peer-to-peer. Dr. Mosier: Ok. Dr. Smith: So we just modify that a little bit. I agree to address the two to three year old question a	

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	little bit. Dr. Mosier: So rather or not you wanted a further definition, because you were wanting to address that. Dr. Millhuff: So then do you want to specifically say we do not approve. Dr. Mosier: No, I was just asking, because when you said four to five, I didn't know that within the prior criteria if we'd done some sort of exclusion. {Several people speak over each other} Dr. Ellermeier: They are going to have to have a peer-to-peer to get approved under six. So if they're three it's a peer-to-peer review unless they're part of the gold card status. Dr. Porter: See, this is the thought I had about that, if there is a Gold Card for this; I wonder if that should not apply for these two to three year old cases. That that's simply always required for these. We really had a hard time figuring out where they came from and what they were since the very first hearing on the law. These cases were the ones that kind of stood out. As unusual. Dr. Moeller: Under three, er, under four, they all get a, going off the next criteria, but I guess we have to decide that. Dr. Porter: I wouldn't Gold Card that. That'd be my two cents. Dr. Mosier: Be under four. Specifically under four, is that what you're saying? Dr. Porter: That's my thought. Dr. Moeller: So we'd want this to be four to five. Dr. Ellermeier: I think it would still be less than six is the limit. But if they are less than four, the Gold Card would not apply for the hard stop of the PA.	

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	Dr. Todd: Operationally we would need separate PA to do that. Dr. Ellermeier: Right. Dr. Todd: Right, in theory. Dr. Ellermeier: Right, but I think dosing still applies. Dr. Adma: I think we need to do something about these three year olds getting these medications. Right? I mean, so, maybe we need to say, less than four, they need to talk to someone. Dr. Ellermeier: I think we need to set these limits regardless of what we do. Dr. Moeller: In case we do have a three year old. Dr. Ellermeier: Yeah. Still need a limit. Dr. Adma: There should be reasons why a three year old is to have this. Dr. Mosier: I am going to ask a question of the MCOs because Dr. Millhuff, he's going to get a lot of those people and he would get PAs. Child Psychologists should be Gold Carded on this, I would think. So, can you distinguish? Dr. Smith: I don't know, I'd ask Dr. Millhuff. Actually, I would think he's probably in the rare situations where he does see most of those; he's probably comfortable doing a PA for four and five year olds. Now, when you hit seven years old that becomes more routine I guess, from a practice standpoint, is a bigger concern, right? Dr. Millhuff: Yes. Dr. Smith: But from an operational standpoint, I do remember when we were implementing the Gold Card, the system limitations for the three BPMs, can we Gold Card based on policy? Per	

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	policy? Or is it per, right now we just have it set up by physicians in NPI. If you're a Psychiatrist all those criteria are just excluded. Do you remember? Dr. Zhou: We can do it per policy based on age. Dr. Smith: We can. Ok, so we can assign at least at our MCO, but I don't know about the other two. Cause that is some kind of a system challenge. Because Chip will be Gold Carded for six and older, but when you write for a five year old, it would stop if you went that route. Dr. Porter: To be clear, the ones that always deserve a review would be the under four. Dr. Adma: Not talking about five year olds. Dr. Smith: Four and under. Dr. Adma: We're talking about three year olds. Dr. Millhuff: I wouldn't say the four and five year olds. I would prefer my Gold Card status for those kids. Because what I see, people who have, children who have Autism. And it's severely dis-regulated. It's disastrous. And they don't become eligible for certain services, certain extra services, until they reach certain ages. And I'll do everything I can to avoid using these meds. Interestingly, there's quite a bit of education in these other systems I've been referencing. One in particular is educating the provider to try non-antipsychotic medicines first, something like an alpha 2 agonist or something like that. Something more benign. Dr. Smith: Well, and that's kind of the other option we had too, when we discussed the Gold Card. Right now it's all Board Certified Psychiatrists but, like for your case, obviously, Child Psychiatrist doing a four and five year old that makes sense, but an Adult Psychiatrist, maybe not. But that'd be your guys' call. Dr. Adma: Makes sense. Ms. Grant: So, on the dosing, how do you want this to read? And then I do think there is an issue	

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	with the MCOs being able to implement. I think if there is a hard PA stop for less than six and then they filter the rest. But I don't think systematic wise; we can do 2, 3, 4, and all these min and maxes. I think we want them in there, but I don't know if they can, from a system approach can do the min and max. I think just a hard stop from less than six, and then we can put the criteria in for following that from the original policy not the dosing policy. Dr. Ellermeier: I would be in favor of leaving this as max dosing. Like, period. And that starting max be integrated into the policy that is already in place for the less than six. Dr. Murff: And then the reviewer could actually load the override such that there's a timeframe for the initial dose. But that could also result in the physician needs to do some taping adjustments and we've only let it override for a specific dose. Dr. Todd: And also, could we like, I know we've done this before with DUR, make these recommended starting max. Right? So the reviewer could speak with the physician's office and say 'this is what our board recommends for the starting max dose', but we not specifically deny the claim if they don't do what we ask. Dr. Murff: Because it would deny over the max limit. One max limit per age, not starting max. I think that gets really complicated. Dr. Todd: I'm really nervous; I'd defiantly have to ask my BPM. I don't think that we would systematically do the two max doses. Dr. Ellermeier: Are you guys ok with this just being the max. Not a starting max, but just the max maintenance dose for this policy? And then addressing the initial starting dose separately? Dr. Moeller: I am. Dr. Millhuff: That's ok. Ms. Grant: There both taken to place once they are PA'd. Pull out the other policy and follow that one.	

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	Dr. Todd: I think it's ok to record them here. But I'm just nervous. I don't want to over promise and say that we can do both of those doses without… Dr. Ellermeier: I think having the maximum total doses the most important piece. The initial dosing is important as well, but I think getting a limit in there is as important. Dr. Mosier: And just a couple of things; one is that, this is our first time looking at it, so we have the next time that it would come up. So we have time. Obviously Florida has operationalized that so we can reach out to Florida and understand how they've done so. All of us. The MCOs can reach out to your counterparts in Florida and we can reach out to our counterparts in Florida and see how they've operationalized it. Dr. Adma: As well as, you know, maybe get some data on what we have so we can look at that too. Dr. Todd: Or that haven't operationalized these doses in their claim system. Dr. Millhuff: Lisa are you saying in that system in Texas it doesn't do a PA like a hard stop? It catches it but it brings it to a review? Dr. Todd: I don't even thing it does it at the pharmacy. I think these Texas doses. Dr. Mosier: Just the people at the table. Dr. Smith: It does now. Dr. Todd: It does now? Dr. Smith: Angie do you remember when? Dr. Todd: Oh, that's the Star Kids. That just happened. So I stand corrected. That was just a couple weeks ago.	

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	Ms. Grant: We always want a hard stop for that. In this situation. Dr. Moeller: I like the idea of reaching out to our counterparts. Because we are all assuming things. Dr. Todd: So we can definitely, on our side, we can reach out to our counterparts, if you have counterparts in Florida and stuff. I know that we do in Florida and Texas. So we can defiantly do that and see how they do it and bring it back. Dr. Millhuff: So is the idea of what I'm presenting of having a minimum starting dose make sense to people? {Several individuals speak in approval of Dr. Millhuff's idea.} Dr. Porter: I think you mean maximum starting dose. Dr. Millhuff: Yes, I got that turned around. Dr. Ellermeier: So, yes. Dr. Todd: It totally makes sense. I think it's just more of how am I going to get my computer to do it. Ms. Grant: So basically, I'll put the Florida data in for the six to eleven and twelve to seventeen and for the less than six, I'll put Florida's data for those two drugs, Aripiprazole and Risperidone and then we'll come back and tweak it more the next time. But I'll add that for next time. And then I'll get data for Dr. Adma and call Florida and see how they implemented less than six. Is that what we want? Dr. Ellermeier: I think we'd like to see the data on who's going to go over these limits. Ms. Grant: The prescribers? Dr. Ellermeier: How many patients are going to go over these limits?	

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	Dr. Smith: Annette, I think if we do pull it, we should pull prescriber type as well. Dr. Todd: Definitely. Dr. Ellermeier: Cause that will be the next question. Ms. Grant: Even if it's just ten children that are over dose, that's important for those ten children. Whether it's high or low, it's about safety for those people we want to protect. Dr. Porter: Yes. Dr. Moeller: Could we have copies at our table next time? Ms. Grant: For? Dr. Moeller: For the documents. The policies. Ms. Grant: Ok. Dr. Mosier: And I'll ask it since we did have the less than six, just to make sure that we're going with just less than six, is there any need to distinguish less than four and four to five? That's the question for you, I think. Dr. Moeller: I think we're going to put maximum doses for less than six. And then less than four we'll address in the policy. Dr. Ellermeier: Yeah, I think we want to see a policy for less than four or a PA policy, separate from the max dosing. Dr. Mosier: Ok. Dr. Moeller: Cause they still may get them, but it would follow these guidelines.	

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	Dr. Mosier: Ok. Dr. Millhuff: So then that would suffice it for limiting that less than six range. Dr. Moeller: Yes. Dr. Ellermeier: I get maybe a separate dose for a one year old versus a three year old, but I don't think we want to tease that far out. I think less than six and settle on that. Dr. Millhuff: I just want to make sure my position clear on this in children three or younger I really don't think we should use these medicines. Dr. Ellermeier: We would need to address that separately. Dr. Moeller: Another policy? Ms. Grant: Could we add it to the other policy that we're getting ready to go to next on the agenda? Would we be able to put that in that policy? Address those ages in there? Dr. Moeller: It's possible. Dr. Mosier: We'll look and see. Dr. Klingler: In the backside of what Dr. Millhuff gave us, I think it has some very lovely comments addressing the preschoolers that could be implemented into those policies. I think the thought process behind those comments above the dosing limits are very appropriate and may be something we want to include somehow. Dr. Millhuff: It's a perfect segue into or next topic. Dr. Mosier: I did think of one other thing we discussed, in terms of your follow up of what to bring next, was the Gold Carding. That this was a policy that did not allow Gold Carding was that what	

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	the discussion was? Correct me if I'm wrong. Dr. Porter: What I mentioned was a different way of addressing what Chip just said. That the under four group, as Chip just said he doesn't think it should be done, we don't want to Gold Card, we don't want it just pre-approved when it gets to that point that children under four are given antipsychotics without somebody reviewing it and having a really good explanation for it. That would be, it has to be addressed this Gold Card issue, but that was the context that I brought up that, basically saying again, we don't really see. Dr. Mosier: And this, what you were saying with the next policy, just excluding that age group takes care of that. Dr. Porter: That would also take care of that. Dr. Adma: The only problem with that process is most of the pre authorization is done by third party people. Right? So we're not talking Psychiatrist to a Psychiatrist for explaining. That's the only challenge. Dr. Ellermeier: I think that we could require that though, right? Dr. Smith: Yep. Dr. Adma: As long as we're able to operationalize that part, I really like the idea of whoever that prescriber is, if they're less than four years, if we can operationalize and have a chat to explain why you're doing that. Ok. Dr. Millhuff: I just want to, I know we need to move one, but do we want to say anything about Thorazine and Haldol in this group? There were some numbers on the Texas document. I don't use those medicines in this age group, but. Do you know of anyone Vishal? Dr. Adma: I sometimes get kids from Lake Mary Center. Dr. Millhuff: Lake Mary Center?	

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	Dr. Adma: Yes. So there are some autistic kids, some Psychiatrists at Lake Mary for example, use some of those older agents. So I really think we need to look at the data. Dr. Millhuff: Let's look at the data, right. Dr. Adma: And then decide. Dr. Millhuff: I would lean against to not even include those. Dr. Porter: If we look at the data on particularly, I know more data is available about Haloperidol, the data in recent years about its' neurotoxicity, it would not be an FDA approved drug today because of that information. So I do think that it was approved many years before all this data was accumulated, so I would say any review would also be about more recent neurotoxicity about Haloperidol and I think other first generation agents, but the data I'm more aware of has more to do with Haloperidol. Dr. Millhuff: That would definitely be supported by practice guidelines or practice parameters to use a second generation. Dr. Adma: Yep. Even as a PRN. Ms. Grant: For all these kids? Dr. Millhuff: The comment I just made would be for all pediatric psychiatry, you would want to use a second generation first and there are cases where you would use them more as a PRN in a hospital. Ms. Grant: That's something we could do with step therapy, maybe later, if you guys want to say 'this drug needs to be first before you try this other one'. See that would be a place where we could put that information in. Do you want me to draft something and bring it to the next meeting? Dr. Millhuff: Let's think about a little bit longer. I'm not sure how to answer that.	

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	Dr. Porter: But at this point, I guess we're not going to add in, even though the data's out there, we're not going to add in Haldol and Thorazine data in the interest of not necessarily encouraging the use of that medication or signing off the use of that medication. Dr. Millhuff: Not in the children that are younger than six. Dr. Ellermeier: So we currently have limits in adults approved for those medications? Do we want to lower those for kids? Dr. Millhuff: It's on the Florida guidelines. Dr. Porter: We just won't add those for the smaller kids. Dr. Millhuff: Right. Not for younger than six. Dr. Ellermeier: So don't use it. Dr. Millhuff: It won't be there. Dr. Adma: So we're not approving any of this. We're sending it back for more data and come back. Ok. Dr. Ellermeier: Thank you Dr. Millhuff. Dr. Porter: Yes, thank you, great work. Dr. Mosier: Does anyone else have any comments on this? Or any other request for data for next time? {Silence} Dr. Mosier: Alright, we'll move on to the next.	

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III. New Business A. Prior Authorization Criteria 2. Antipsychotics for Children Ages 13 or Younger- Requested review	Dr. Mosier: *Antipsychotics for Children Ages 13 or Younger,* review requested. Ms. Grant: It was asked to review this again and I'm not sure if the request was to go over the dosing part again or if it was to go over the whole criteria. That was not given to me and I guess I failed to ask for verification. So if it's just for dosing, we've covered that. If it's for other issues then… **Clinical Public Comment: -** No requests were received. **Board Discussion:** Dr. Millhuff: I mentioned it, not because of dosing matters but because of we've been living with this for a little while now and I guess I want to give some feedback about that. And we approved this, the committee approved this back in October of last year and I reviewed those minutes last night, there were a number of questions in the review about things like: What are the guidelines with a cap on lab monitoring. How do they compare to the American Diabetic Association. There was some uncertainty in the discussion and I've got some information I could share about that. There was also a considerable amount of discussion about diagnoses that would be included in this; I don't know if there is a need to take a lot of time on that. I have a couple comments with that. The other thing is just the, I'm trying to get clear in my mind, the PA process with these medicines in terms of if you don't have all the criteria we created, there's a few things coming up like abrupt cessation of an antipsychotic medicine which is not, that is clearly not recommended in best practices, I've heard of some examples of that from my counterparts in the mental health centers. And so, there's a number of things here. Ms. Grant: There is the 60 day override but, I guess my question is on the 60 day override, is that for tapering on and off or is that for saying someone can start on it for the first time has 60 days to be on it and then we're going to go ahead and tell them they can't? So I guess I would like to clarify the 60 days. Is that tapering 60 days? Because it really doesn't say on there, it just says a 'one time override'. Dr. Millhuff: So, I wasn't at that meeting, so I'm not exactly sure, I just read the minutes and maybe some of the others who were here could explain that a little bit better. My understanding is that if	The criteria were discussed and will be brought back to the next MHMAC meeting.

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	you didn't have all the data, let's say the lab work. You've got an eight year old who's got a mood disorder and they're aggressive and have some psychosis; you've got to start that med because they're in crisis, but it's going to be very difficult to get a lab draw in an outpatient setting. So the 60 day override for that new start; that's my understanding of one reason why that's in place. Dr. Mosier: Well, let's do this. It sounds like we have several different areas, why don't we start from the top and we'll start with the meds. Is there any changes in meds; additions because some new may have been approved or something. And then we'll work through each piece of that and address that as we go through the policy. So for the medicines listed any additions or changes? Dr. Ellermeier: Just to clarify, I think we have this broken down in six and younger and then above six? Ms. Grant: Yes, six and younger and then seven to thirteen is how it's broken down. Dr. Ellermeier: Ok. Thank you. Ms. Grant: This does have the new Vraylar and Rexulti on there. I don't know if there's any other ones since those two. Dr. Adma: Let's go down. Let's look at the criteria. Ms. Grant: So for ages six or younger, must meet all of these. I don't know, something I noticed on the diagnostic part, it doesn't seem to be complete like schizophrenia or anything like that. Dr. Mosier: Going through in order, so for meds we want to do that first. Anything with changes for meds? Dr. Millhuff: There are things on that med list that we have not approved in terms of dosing. Dr. Todd: But this is not dosing, this is just if the drug is going to require PA. Ms. Grant: And on the dosing, Dr. Millhuff, I took that exactly from the last document that had all	

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	these meds. Dr. Millhuff: Correct. And that document doesn't include some the meds that are on this list. Dr. Adma: Like Vraylar is probably not on that list. Dr. Ellermeier: I would think we would still want those medications just in case for PA regardless of the dose. Dr. Millhuff: I see what you're saying. That makes sense. Dr. Adma: So let's go down and I think Chip you had a question about the waist circumference, right? Dr. Mosier: Let's do diagnoses next and then we'll do the labs. And then we have clarifying the process and making sure we don't have abrupt cessation and then we have the under three issue, so let's just take that in that order. So going down to the criteria and the diagnoses. Dr. Ellermeier: So we have six and younger now, should we change it to four, five and six? Dr. Moeller: I was curious about that too. Keep our age ranges. So we are requesting to amend this current policy. Ms. Grant: As the previous discussion we just had, I guess that would be the situation. Dr. Moeller: Do we want to make the ages align with the ages we plan to use with the max doses? Dr. Ellermeier: That makes sense. Dr. Moeller: Because the thirteen but we're going with twelve. So, I mean, I just… Dr. Porter: That makes sense.	

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	Dr. Millhuff: I would agree with that. Ms. Grant: Ok. Dr. Moeller: So we want prior authorization for antipsychotics for four to five year olds and then we'll have a policy for three and under. Dr. Adma: No, don't take it out. Dr. Ellermeier: No, she's just going to copy and paste it so we have another one to amend. Ms. Grant: And then you want to say four to five? Or how do you want to do this? {Several say 'three and younger'} Dr. Ellermeier: And I think that we remove all of that and make it a peer-to-peer consult. Dr. Smith: Or just say 'not covered'. And then it would be an appeal. Dr. Ellermeier: Then it would require an appeal? Dr. Smith: That would be a peer-to-peer consult. Dr. Ellermeier: If you guys are comfortable with that? Dr. Adma: The only thing is, operationally, what we really want is the Psychiatrist to able to talk to another Psychiatrist. Dr. Smith: And an appeal would facilitate that quicker. Right? Dr. Moeller: How long does the appeal process take? Just so I understand, so it would be a deny and then the doctor would have to appeal it. So it would take?	

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	Dr. Todd: I think an appeal is usually fourteen days. Ms. Grant: Seems like in our literature it says thirty days or seventy-two hour expedited appeal. Dr. Smith: You could do an expedited appeal. Ms. Grant: So, seventy-two hours. Dr. Moeller: Cause I can't imagine any criteria for why you would need. Dr. Adma: There's always exceptions, there might be kids who are less than four on psychotropics, so what happens if they're already, now, on it? Dr. Smith: For right now, we've grandfathered everything. So if people were already on these, they got grandfathered for the length of time of the current PA. So for six months there was no PA requirement at all to interrupt therapy. Dr. Porter: You kind of have to invent a scenario. Because, again, everybody at this table has said it's hard to imagine a three year old on an antipsychotic, but the problem, the scenario you could invent where that would be a problem that we just setting up would be if somehow a child was in a facility of some type and was placed on an antipsychotic for a reasonable reason, which we've had a hard time defining what that would be, and they showed up to get a prescription. And it was something that was helping them in some way, they then would then be off that medicine until the appeal was done. Dr. Adma: So what Ty is bringing up is if they were hospitalized. In a psychiatric hospital. Dr. Moeller: Could we allow a fourteen day override? Dr. Ellermeier: If they were already on it. But if it's a new start. Dr. Todd: You'd almost need a peer-to-peer. So you could ask. You know, to talk about the situation.	

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	Dr. Porter: Again, we have a Child Psychiatrist who says he doesn't think kids should be on these meds anyway, so I don't know how we… Dr. Millhuff: It's a very, you know, I can see a large three year old who is for instance, autistic, non verbal, and very aggressive, dangerous, lighting the house on fire, the parent that's extremely overwhelmed and you're doing all you can from a psychosocial standpoint. You've tried other med categories and it's just, you go through a process of elimination, but it's rare, Ty. And the idea of a three year old or younger being in a psychiatric unit. Dr. Porter: They might come out of Children's Mercy on more of a medical. Dr. Millhuff: Oh. I was thinking in my shop that would be very unusual. Dr. Porter: I was just trying to think of a scenario that would be a problem with what we're saying and this one, if they really needed it, and they came out of the hospital on it, and they wouldn't be able to get it. Dr. Moeller: Could you tell us, because I remember we looked, that it would be maybe five people this may have affected or something? I mean, I'm just guessing. Could you give us that data? Dr. Adma: I think it was double digits. I think it was nineteen or something like that. So I think it was higher than five. Dr. Moeller: I think there was like a two year old on it and I just can't imagine a two. Dr. Millhuff: I think the likelihood of us creating a safer environment for our Kansans is much, much greater than the risk because one of the issues that happens is you have really stressed systems where the child, they really need more psychosocial support and you say 'oh, I'm sorry, the State just won't let me prescribe it, you're too young' and in some ways that's a little bit of a back up because prescribers really get pressured, like 'we're desperate, we have no one', so this kind of reinforces that we need to lean on psychosocial interventions which I think that would be a good thing.	

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	Ms. Grant: Here's some information from Liane. And I'm not sure; The legislature on psychotropic, what is it exactly? Dr. Ellermeier: Less than three. Just a little lower. Ms. Grant: A little lower. Dr. Mosier: If we could enlarge that. Ms. Grant: Ok. Dr. Smith: That's psychotropic though not antipsychotic. Dr. Moeller: There. Is that sixty-nine? Dr. Porter: Sixty-nine. Dr. Todd: Oh wow. Dr. Adma: How much? Dr. Porter: Sixty-nine. Dr. Adma: Antipsychotics is sixty-nine? Dr. Millhuff: Wow, that's amazing. Dr. Moeller: Twenty-six percent of the population. Dr. Adma: Twenty-six percent of three or under there? Dr. Moeller: Are there two or more?	

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	Dr. Ellermeier: Yeah, two or more, three or more, four or more, five from any of the categories. Dr. Adma: Of these, do you know how many are being prescribed by a Child Psychiatrist versus non Psychiatrists? Dr. Todd: These, we didn't have the data for that. {Several people talking over each other} Ms. Grant: Do you want me to try and look through? I did load some of her documents. Dr. Smith: For Sunflower it was 25% Psychiatry, 25% Mid-Level Psychiatry, and 50% other. Dr. Klingler: I think if that 50% has BD with primary care we need to feather that out. I think the primary care is where we need to change behavior more than psychiatry and BD. Dr. Moeller: I support the three and under hard stop with an appeal because you're still getting an appeal and you're getting a peer-to-peer so they can address that other things have been tried, a social technique has been tried, as other things. Ms. Grant: I think this is the one you want to look at; it says age zero to five. Oh no, that says, down at the bottom right. Antipsychotics by provider type. Dr. Adma: Enlarge it please. Dr. Moeller: 25% is by Psychiatrists. Dr. Ellermeier: This is for over thirteen. Dr. Smith: This is for the whole thing. Dr. Ellermeier: So this is not	

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	Dr. Todd: It's not just the young, young kids. Dr. Porter: I think if memory serves, we weren't able to get the young provider data. Dr. Todd: I just don't think we pulled it. We can get it. Dr. Ellermeier: If we post changes, will it still have to come back to the next meeting? So I say we post changes and ask for provider type data for the next meeting before we do our final sign off on this. Dr. Adma: Ok. Dr. Moeller: Do others support? Nicole, do you? Dr. Ellermeier: I think I do on three and younger for a peer-to-peer. At a minimum. Dr. Moeller: Is there a difference between peer-to-peer and an appeal? Dr. Todd: Yes. Dr. Smith: When you do a peer-to-peer, you can do it on the original authorization request, where as you do an appeal, you prior auth, you're denied, and then you appeal. Dr. Todd: It's quicker to do a peer-to-peer. Because you're going to get that done within 24 hours. Dr. Moeller: Like for safety. Concern about the kid starting fires and things, a peer-to-peer would address that. Dr. Ellermeier: Yeah, I think it's three and under require a peer-to-peer. Dr. Moeller: I like that.	

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	Dr. Porter: If I might, this is related because we're talking about the difference between an appeal and a peer-to-peer. This gets back to the process issue of the PA. And I know we've kind of put this aside for a little bit, if I could just have a minute, I want to remind people, what we're doing makes perfect sense, let's keep in mind what's out there, will you? Almost all the Medicaid recipients are going to be at mental health centers. Mental health centers here and in other states are very stressed organizations. They are financially stressed. They have a hard time keeping staff. They have a hard time getting patients in. Laying people off. Right now, these will accumulate. I feel like, so just go back for a minute, so a peer-to-peer, a phone call to the plans Psychiatrist, we throw this term around every time and I want to put it off, I bristle at it because at a minimum a call to the plans Psychiatrist eliminates one patient slot that day at a minimum. Not to mention any additional phone calling and staff work to do it. And so, whereas, I think for an appeal, a peer-to-peer as a phone call is the only way to do that. For the initial PA process, when it's a phone call, we are interfering with the MHCs ability to operate, with their ability to retain and keep staff, when you have a Psychiatrist on the phone from a MHC, that's a half hour or a patients slot where he can't bill, so it hurts him further financially so, we need to get back to it, but again, for the standard PA, it needs to be something, a form, that can be filled out and sent in between meetings, at lunch, after work, and not take a patients slot out of the day. If we finish this whole process and it ends up that we send out saying something on a routine PA that says call the plan Psychiatrist, then I, and I feel the committee, has failed to really protect the mental health centers and the patients in this state from unnecessary burden. Dr. Moeller: For a three year old. Dr. Porter: I admit that this is a broader topic than what we're talking about and even off topic, but every time we throw out this thing of peer-to-peer on a PA, I just have to not do it and tend to go off about it. I wanted to state that and we can get back to whatever we need to. Dr. Mosier: And we can bring that to the next meeting, if you guys can bring potential proposals, you can share that and we can have that as our Section 4 discussion next time. Dr. Ellermeier: Dr. Porter, I think those are great points. I think we need to be diligent and careful and when we say a peer-to-peer is required, I think that's a good point to make. I do think we would be really challenged to come up with standard criteria for three and under and I think this is a place	

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	where it's probably appropriate. Dr. Porter: It's definitely where it's appropriate. Dr. Smith: I would just say in general, I personally can't see any criteria coming forth, new criteria, where that would probably be an option. I think the hard part was when we started with nothing and we started with the most challenging situations where we have struggled to figure out what would be an appropriate situation and how would we write criteria because they are so one off. So I guess that will continue as new criteria comes forth in general. Just because of that outlier situation. Dr. Moeller: And I think when we talk about peer-to-peer, we're really talking about safety. Often for the patients. There's two ways to look at it, but thank you. Dr. Millhuff: I have extra comments to make on that but I'll hold, because we've got to move on. Dr. Mosier: We'll bring back proposals on how to solve that. Ms. Grant: So are we adding this three and under or are we changing it all and bringing it back? Dr. Ellermeier: I think we want to add the three and younger now so we can potentially approve it at the next meeting. Dr. Klingler: And I think on the three and under I would like to think about including the sentiments in this Florida document about the use of psychosocial interventions. Dr. Ellermeier: What's up there is what we would like to add. Dr. Millhuff: Six and under or three and under? Dr. Klingler: Either six and under or three and under, but I felt very strongly about three and under that I think that if we include that, it sends a message. Ms. Grant: Those three bullet points for the three and under is what you want me to put?	

	DISCUSSION	DECISION AND/OR ACTION
	Dr. Klingler: Yeah, about psychosocial interventions. I don't know if we need to re-word it or if we can borrow verbiage. Dr. Millhuff: It just says things that we've kind of gotten at. A little bit more specifically. And it emphasizes that evaluation really needs to be clear and done prior to getting to these meds. That treatment should be in place before we use the meds. Pretty much says it straight forward. Ms. Grant: So you want me to put in there 'Patient has developed appropriate and comprehensive…, 1, 2, 3 is that what you want me to put in? Dr. Klingler: I would go from the use of antipsychotic medicines down to the end of bullet point three. I think that whole thing would be nice to include. Dr. Mosier: These will be just yes or no questions. We have to… Dr. Ellermeier: I get where you're coming from for three and younger, but I actually think three and younger should just be a peer-to-peer, and let that address these issues and then six and under maybe has this in it. A peer-to-peer consult would be the criteria for three and younger. Dr. Millhuff: That's it? Dr. Ellermeier: That's it. Dr. Millhuff: That's it and will go up to the next age group and add this. Dr. Ellermeier: I would also, I would also recommend, I hate to say this, because of the kids that are currently in this age group are grandfathered in, so this would apply to new starts, but there would not be a 60 day override prior to approval. If we're saying we can't think of a case where it is generally acceptable for three and under to be on any antipsychotic, I don't think we should allow overrides. I think it should just be the peer-to-peer to start. Dr. Millhuff: Agreed.	

	DISCUSSION	DECISION AND/OR ACTION
	Ms. Grant: So is this how you want me to leave this for three and younger? Dr. Todd: What do you want to put for the approval length? Dr. Ellermeier: I think 6 months is fine for the approval length. Ms. Grant: But there's no overrides. Dr. Ellermeier: Once the peer-to-peer is approved, if they want to approve that medication for six months. Dr. Smith: They'll probably be four by then. Dr. Ellermeier: Yes. Dr. Millhuff: I agree with that. I really think we are trying to dissuade people from using these medicines. Dr. Ellermeier: I think four to six you can make an argument. Dr. Adma: So are we saying four and five actually? Dr. Moeller: Four to five, yeah. Dr. Adma: Because six we have. Dr. Millhuff: Yes. Dr. Moeller: So the next thing we want to propose is five and younger? Dr. Adma: Four and five years.	

	DISCUSSION	DECISION AND/OR ACTION
	Dr. Smith: Currently, it's four, five and six. Dr. Mosier: And that was if we were, Jonalan, making it consistent with the Florida policy since it says six to eleven and twelve to seventeen. Dr. Moeller: We're trying to make it consistent with our dosing guidelines. Dr. Adma: I think people will be confused if you say four to six. Then that six will be included in that. Dr. Moeller: You've got to say four Ms. Grant: Say less than six? Dr. Ellermeier: Yes, but if you say four to five years and one month it goes to the next one. Dr. Adma: Four and five. Dr. Todd: The computer goes by days so if you're a day over five years old it's going pump up to six. Or just say less than six. Dr. Millhuff: Yes, less than six. {Everyone talking over each other} Dr. Ellermeier: Greater than three and less than six. Dr. Millhuff: That was a good call. Dr. Klingler: 48 to 60 months would then take the ambiguity out of it. Dr. Todd: Yes, but the computer does days.	

	DISCUSSION	DECISION AND/OR ACTION
	Dr. Smith: So then do you want to change the top one to less than four? Dr. Ellermeier: Yes, er, no. Dr. Moeller: That's why I'm confused. Dr. Smith: Because if you're three years and eleven months. Dr. Moeller: Yeah, I thought that would get the three and eleven months. Dr. Smith: I think the intent was… Dr. Ellermeier: Less than four. You're right. Dr. Millhuff: Less than four. Ms. Grant: But it says less than three on the next one. Dr. Mosier: Now how does your system do it? Dr. Mosier: If it's three and then three and one day, does it consider? Dr. Todd: If it says three or younger it would be equal, you know, equal to three. Dr. Ellermeier: I think it's less than four years of age for that one. Ms. Grant: Would that go with the Florida data that we have? {Several 'yeses' are heard} Ms. Grant: So, four or younger here? Dr. Smith: Less than four.	

	DISCUSSION	DECISION AND/OR ACTION
	Ms. Grant: Less than four? Dr. Ellermeier: Yeah, you don't want to include four. Ms. Grant: Four. Ok. Yeah. Dr. Ellermeier: And then the one below needs to be greater than four. Dr. Murff: You want four included though? Dr. Ellermeier: Greater than or equal to four, right. Dr. Moeller: So you just need age four. Do you have to have the 'greater than or equal to'? You could just say four. Dr. Ellermeier: I think so because the other one is less than four. Do you guys understand the intent? Dr. Smith: Yes. Ms. Grant: Is this correct? {Yeses can be heard} Ms. Grant: Are we leaving the criteria the same? Or did you want to add the Florida document information like Dr. Klingler suggested? Dr. Mosier: The Florida document information, in general, would be in addition to these. Ms. Grant: In addition? Dr. Mosier: Yes, they would not be replacing.	

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	Dr. Ellermeier: So, the one, I like the Florida data but then I am concerned, how would you operationalize? Like, how is that a form? I think we still want to keep this somewhat simple. I don't know. I'll defer to you guys. Dr. Millhuff: Well, the first line there 'Must be prescribed by or in consultation/collaboration…', I have no questions about that bullet point, right. Then the next one about diagnosis, I'm going to send one more thing around to you guys. I copied a page out of the 'Practice Parameter For The Use Of Atypical Antipsychotic Medications In Children And Adolescents' as printed by the American Academy of Child and Adolescent Psychiatry. Table one shows the evidence for the use of atypical antipsychotic and we've got most of these diagnostic categories covered. Just the easy changes that I would recommend is to keep with our DSM-V would be changing Autistic Disorder to Autism Spectrum Disorder. It's getting a little bit picky but it's keeping up to date with how we label that condition. And we have on there-Tourette's syndrome is now labeled Tourette's Disorder. Just again, the proper nomenclature. Ms. Grant: Autism Spectrum Disorder? Is that what you said? Dr. Millhuff: Yes. Autism Spectrum Disorder. Ms. Grant: And then what was the next? Tourette's? Dr. Millhuff: Yes, take out 'syndrome' and put 'disorder'. And Autism; oh I see what you're doing. Ms. Grant: I just struck it through. Dr. Millhuff: And I don't know if we have time to talk about this today, but there was a lot of discussion about disruptive behavior. Vishal, I think you brought this up in October, and we ended up taking it off the table. But as you can see from this chart disruptive behavior disorders and related aggression is a, there is very good evidence that atypical antipsychotics work for those kids. Dr. Porter: Chip from my end, those are all Bi-Polar and they do fall out under mood disorder in the DMS-V and they would be included if we leave that on there.	

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	Dr. Adma: Mood Disorder is a broad category. Dr. Millhuff: Right. But what I'm thinking about is specifically, when you look at these studies, looking at Conduct Disorder, Oppositional Defiant Disorder, we have kids with severe ADHD problems and, keeping in mind, that a lot of these children have comorbid conditions like Post Traumatic Stress Disorder, Attachment Disorders, and they don't neatly to be fit into a Bi-Polar box is what I'm getting at. So, I don't know if I want to take the time to persuade everyone to add more to that diagnostic list, but added for just a little bit of a follow up. Dr. Porter: The category missing, we have Mood Disorders, which covers some of the things, but it would be that sub category about, that includes ODD, even CD, as a separate category. Dr. Adma: Those are? Dr. Millhuff: Disruptive behavior disorders, right. And, so, we don't have that here. Dr. Porter: Yes. Dr. Millhuff: It does open up the doorway much wider because we see a lot of kids with disruptive behavior disorders, but what we're thinking about, like with our Autistic kids, this is marked mood instability agitation, not all Autistic kids are going to qualify for being on atypicals as do many of the kids with severe behavior disorders. It's just that if I can't say 'well this kid doesn't have Bi-Polar they don't have Autism, they don't have schizophrenia, they don't have Tourette's.' Dr. Porter: They also don't have any recommended medications. Dr. Millhuff: Yes. Dr. Porter: I mean for that disruptive behavior disorder category, right? Dr. Millhuff: The FDA has not approved antipsychotics for that age group but there's evidence in the literature for its use for those conditions.	

	DISCUSSION	DECISION AND/OR ACTION
	Dr. Moeller: We're reviewing four to six years of age. Dr. Millhuff: What? Dr. Moeller: Remember we are reviewing four to six years of age. Dr. Millhuff: Yes, but these show up on the next level as well. Dr. Moeller: I like it without the disruptive. I think we're now allowing the most open situation for prescribing and I think adding disruptive, we're just going to allow more with this diagnosis. It's going to really open this up to. Dr. Millhuff: I hear what you're saying but also have looked at these other systems and they're qualifying antipsychotic medicines for disruptive behavior. Very clearly delineated in for instance the Florida algorithms where they say, they're processing 'what have you tried first? Have you done all these things?' and then they're getting to 'ok, you've gone through the process of elimination'. Dr. Moeller: But we don't have a tier system in here. And, so, there's even in the safe prescribing, it's really recommended not to use these for behavioral stuff. Dr. Millhuff: As a Child Psychiatrist on this committee, I just wanted to bring that to the table as a follow up to the initial discussion and maybe down the road. Dr. Adma: Karen, at least in my experience, Karen, I agree with Chip because Psychiatrists do prescribe for symptom management too, not just the diagnosis. Dr. Mosier: But we have to think about all prescribers. And I think that's where the discussion went the first time that we were looking at all prescribers being able to do this and, potentially, that being a lumped diagnosis that might be utilized. Dr. Porter: Are we still talking about a certain age of children in this conversation? Ms. Grant: Four to six.	

	DISCUSSION	DECISION AND/OR ACTION
	Dr. Moeller: And I believe the APA has in the Choose Wisely campaign, do not prescribe these for behavioral first line and stuff like that. So, I mean, I can bring those too as a document. Dr. Porter: This discussion, Chip, would it be different if we're talking about the four to six year olds and the older children? About the disruptive behavior disorder and atypicals? Or would it be the same? Dr. Millhuff: It would be the same, I'd say. Because the same diagnostic labels are in the next level up age wise. But I'm saying from a clinical standpoint, I use these medicines for kids that are in severe duress. Dr. Porter: In the four to six? Dr. Millhuff: In the four to six range, yes. Dr. Moeller: Didn't we kind of say that Psychiatrists in that would have the Gold Card? And so, Dr. Millhuff: Yes. That makes it work. Dr. Mosier: Ok. Dr. Millhuff: But, I want to add, this is piggy back a little bit on what Ty was saying earlier about we have a lot of Nurse Practitioners that are directly under the supervision of a Child Psychiatrist or Psychiatrists that are managing these kids as well. And that's one of the big feedbacks that I've been getting as to the load of PAs that are coming up because they're not, because they're working with a lot of kids too. I know that's our last agenda item, but, in terms of mental health centers that got a lot of these kids, it does make it a lot easier for the Psychiatrists to not go through PAs for some of these kids that are kind of border line. I'm just saying, as we get to the other agenda item; really consider adding our Nurse Practitioners who are directly under the oversight of a Psychiatrist to that Preferred Prescriber Status. I pulled our group of mental health providers in community mental health centers, before coming here, and talked about this in our annual meeting. I got a lot of feedback that the PA process is very burdensome. They had some; one place said our engagement	

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	specialist is spending all of their time doing PAs rather than engagement work. And other examples, twenty to thirty minutes to do PAs, up to 72 hours to kind of get final authorization, what really is upsetting people is to do a PA and then find out it wasn't necessary. So, it's consuming a lot of time, and it gets to Ty's point about, we're running thin with our ability to meet the demands of our children and adolescents with pretty severe psychiatric difficulties and it gets to we got to be careful with what we are putting these parameters because of how it's going to stress the system. So that's a little bit of feedback from living with this for a few months for what I'm hearing from others. Dr. Porter: Dr. Mosier, I'm going to have to excuse myself. Am I allowed to give a proxy if my vote comes up? Dr. Mosier: We won't be voting on this. We'll be discussing it. So, this will come back next time. You're good to go, you don't need a proxy. And we are overtime, have about five minutes to continue discussing this. For the purposes of next time, the Preferred Prescriber Status and then other process and improvements that we just discussed, that we'd bump that up. What I'd like to propose is that next time is that we take the first items we discussed today, complete the discussion of the second item, have those be the first item of business under old business, then do the Process Improvements and then, if time, we'd take on new. Does that sound good to everyone in terms of how we can get to that and not have it be lost at the end of the discussion? {No opposition was heard.} Dr. Mosier: So we'll do that. Ok, so, we've gone through this. Is there anything else on this? Dr. Millhuff: Just one more comment. Since I handed this out to you, on the second page; it's kind of the next issue on there, which is the monitoring criteria. I looked at different guidelines and such. The waist circumference gets mentioned by the ADA guidelines way back when and that was for adults and whoever. You don't see it in practice guidelines as much; you'll see it listed kind of in reference to ADA. That and the other thing is, if you look at this chart here, we're asking for all these things to be done every three months. It's really not; I don't completely understanding the logic of that. It seems too frequent to have blood draws. Dr. Ellermeier: I don't think we're asking with it every three months, I think we're just asking if the	

	DISCUSSION	DECISION AND/OR ACTION
	initial was done within the past three months. Dr. Millhuff: So if you had a person that is starting atypicals and was on it for four months and they have to switch to another one, would they have to do another blood draw? Dr. Adma: That's a good question. Dr. Ellermeier: If you approve one of these meds, are all of them approved? Dr. Murff: I think it's allowed to do dose changes, but I think it is for the specific antipsychotic. Dr. Smith: Yes, you are correct Chip. The way that it is currently written, that's correct. Dr. Millhuff: And currently you have to do a PA, tell me if this is correct, every time you change a dosage? Dr. Todd: Dose changes are covered. Dr. Smith: You should not. The PA should be by, and I think we all should have it set up that way, should be by drug. So if you ask for Geodon, you'll get Geodon, regardless of strength. Not Geodon40, Geodon80, but, you're right, if you got the PA for Geodon and then you want to switch them to Abilify, then the Abilify is going to require that and, you're right, if the lab work might not be within the last three months if they're four months into the Geodon. So, I think that's an opportunity. Dr. Millhuff: I think we could configure these recommendations a little bit differently so that the ones that need to be done more frequently we have a different time limit on that. Like blood pressure, pulse, height, weight. Height and weight especially, that should really be done every visit. Ms. Grant: Do you want to send those to me? Dr. Millhuff: Yes.	

	DISCUSSION	DECISION AND/OR ACTION
	Ms. Grant: Then I could fix it for next time. Dr. Millhuff: It's a proposed change. Dr. Ellermeier: What if we also add that for initial they have to meet those three or when switching from a different agent. Dr. Smith: The opportunity might be, and I don't know, you guys will have to tell me if it's reasonable to switch from the lab work from being in the previous three months to the previous six months. Is that too far out? Dr. Todd: That would be the length of approval. That would match the approval. Dr. Ellermeier: That makes sense. Dr. Moeller: I think that would be fine. Dr. Smith: And Chip did you say take off waist circumference? Dr. Millhuff: Yes. Dr. Adma: Yes. Ms. Grant: Take off waist circumference? Dr. Mosier: Yes. Dr. Moeller: The only thing is I know you say we're not doing it in clinical practice, but should we be doing it in clinical practice? Dr. Klingler: I don't think I've ever seen a waist circumference done on a child younger than six. I don't know what the rationale for doing it in clinical practice would be.	

	DISCUSSION	DECISION AND/OR ACTION
	Dr. Smith: I think this was for the base line so that you could see if they added two inches. Dr. Klingler: But kids grow at height and length not at a consistent rate. And so, I can't imagine a situation in a growing child of that age where it would be accurate because they don't grow proportionately in height and weight at the same rate. Dr. Millhuff: I've got an example of someone that got a denial because he didn't have the waist circumference. And that's kind of ridiculous. We're trying to set the bumpers not real tight but so that we catch the more gross problems. Dr. Ellermeier: I agree. If they're doing everything else and they're not getting the waist circumference… Dr. Moeller: I agree. The height and weight are more. Dr. Millhuff: The height and weight, blood pressure, and pulse. It also needs to also say fasting blood glucose, that's important. Those are just kind of the main things. Dr. Adma: Ok. Dr. Smith: Could you scroll down, Annette? Ms. Grant: I'm sorry, Jonalan? Dr. Smith: I think seven to thirteen has similar… Ms. Grant: I was going to ask if you want me to do the same changes to the other ones. Dr. Adma: Yes. Dr. Ellermeier: I think we redefined diagnosis too? Dr. Millhuff: Right, the diagnosis should change as well.	

	DISCUSSION	DECISION AND/OR ACTION
	Ms. Grant: Change the diagnosis to exactly like… Dr. Millhuff: Yes. Dr. Ellermeier: We have some different ones already, but the same changes; Autism and Tourette's. Dr. Adma: So there is hyper active behavior? I thought we changed all these? Ms. Grant: This is the one that was approved and this is the one being implemented. Dr. Mosier: I think there is an updated one. We need to go back to what the DUR had because I think it conforms exactly between the two. Dr. Moeller: I know we didn't do hyper active. I didn't think we did problem behavior. Dr. Adma: That was the first edition. {Several speaking over each other} Dr. Moeller: We'll make sure we have the correct one. Ms. Grant: We have to bring back this anyway. Dr. Adma: Ok. Dr. Ellermeier: Do we need to look at the renewal criteria? It's farther down. So, on the renewal criteria, Chip do you think if it was a two year old, would it capture on renewal or do we need to tweak out? If it's gotten approved, I think that probably works. Dr. Millhuff: Yes. Dr. Moeller: Do we need to change the ages?	

	DISCUSSION	DECISION AND/OR ACTION
	Dr. Millhuff: I think we should adjust the age ranges to be consistent with what we're doing. The other thing is, that statement about 'unless behavioral modification therapy is documented to be ineffective'. That's a little bit too black and white. I mean, partial response to therapy is very common. It can become ineffective and quite frankly what… Dr. Adma: I don't think this is the most updated version. Dr. Moeller: Yeah. Dr. Adma: So we aren't looking at the most updated version. Dr. Mosier: We'll get the one from DUR. Dr. Smith: Annette, on the seven to thirteen, on the lab work, I don't know since the length of approval is 12 months do you want to change the lab work to 12 months? Dr. Millhuff: I think 12 months. Ms. Grant: I'll make those changes on wherever the most current version is. Dr. Todd: I think it's the July DUR. So we could look in that folder. Dr. Mosier: Are there any other comments on this? {None heard.}	
IV. Process Improvement Initiatives A. Preferred prescriber Status	**Board Discussion:** {This item moved to the next MHMAC meeting in February 2017}	For informational purposes only. Moved to the February 14, 2017 MHMAC meeting.
V. Open Public	**Public Comment: -** No requests were mentioned	

	DISCUSSION	DECISION AND/OR ACTION
Comment*	**Board Discussion:** Dr. Mosier: So the next meeting will be on Valentine's Day. We'll be spending Valentine's Day together, thank you. So we will change the order. We will bring up these two that we discussed under new business today under old business first and then we'll go directly from there to process and improvements and discussing preferred prescriber status as well as streamlining PAs. Dr. Ellermeier: Could I make a comment about the meeting time. I appreciate the morning and that the brain is a little more awake. But, well it's Valentine's Day and people may not want to stay late to finish the meeting, but I do think this is a harder time if we need to go overtime in the morning, people are trying to get to their jobs. So maybe we either plan for a longer meeting or change the time. Ms. Grant: Typically this is not the time, but because it was rescheduled I had to go with what I was given for choices. Dr. Ellermeier: I understand. Dr. Adma: We used to have the afternoon. Dr. Moeller: Do we know what it is for Valentine's Day? Ms. Grant: I assumed we'd go back to the usual time. Dep. Sec. Dunkle: We usually go to 4:30-4:45. Dr. Todd: Should we go 2 to 5? Dr. Moeller: Don't we have to be out of the building by? Ms. Arace: We have to be out of the building before 5pm.	

	DISCUSSION	DECISION AND/OR ACTION
	Dr. Mosier: 2 to 4:45? Dr. Ellermeier: 1 or 1:30? Start earlier? Ms. Grant: You could take a vote. Dr. Moeller: I'm fine with 1 o'clock. Dr. Ellermeier: It's a lot harder for you to make it at 1? Dr. Adma: Yes. Dr. Klingler: As clinicians, if we only have to block a half a day, and not have to use part of the morning to drive and that's where it gets hard for clinicians. I'm sure Chip and Ty and the rest of us who are practicing will have to reschedule patients. So if we could nail it down and not have to reschedule the morning; that would be excellent. Ms. Grant: 2 to 4:30, is that what I'm hearing? {Several in agreement}	
VI. Adjourn	Dr. Mosier: Alright. We are adjourned. Thank you very much. Sec. Mosier adjourned the November 30, 2016 Mental Health Medication Advisory Committee meeting at 11:22am.	
*Clinical and open public comment requests and written testimony must be submitted one week prior to meeting to Annette.Grant@ks.gov. If providing clinical comment, please indicate which agenda item you are requesting time to comment. Time limits during period of comment will be determined based on number of requests received. The next MHMAC meeting is scheduled for February 14, 2017.		